

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011648

STATE FILE NUMBER

FILED MAR 23 1959

Registration District No.

317

Primary Registration District No.

541

Registrar's No.

726

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clayton Missouri</u>		c. CITY OR TOWN <u>Clayton, Missouri</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis, County</u>		d. STREET ADDRESS (If outside, give location) <u>6064 Kinsington</u>	
3. NAME OF DECEASED (Type or print) First <u>Thelma</u> Middle <u>Hartenfield</u> Last <u>Stewart</u>		4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6, 1922</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steak and Shake</u>		11. BIRTHPLACE (City and state or country) <u>Mississippi</u>	
13a. FATHER'S NAME <u>Wash Heartfield</u>		14. NAME OF HUSBAND OR WIFE <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>428-46-8734</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebro-Vascular Hemorrhage</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>3:20</u> Month, Day, Year <u>3-13-59</u> a.m. <u>A</u> p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY <u>St. Louis</u> STATE <u>Missouri</u>	
21. I attended the deceased from <u>3-13-59</u> to <u>3-14-59</u> and last saw her alive on <u>3-14-59</u> Death occurred at <u>3:20</u> A m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>J. G. Harrison, Jr. M.D.</u> (Degree or title)	
22b. ADDRESS <u>601 So. Brentwood</u>		22c. DATE SIGNED <u>3-14-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/19/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
24. FUNERAL DIRECTOR <u>E. B. Keane</u> ADDRESS <u>1221 N. Grand Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>3-18-59</u>	
26. REGISTRAR'S SIGNATURE <u>J. G. Harrison, Jr. M.D.</u>		27. REGISTRAR'S SIGNATURE <u>J. G. Harrison, Jr. M.D.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed Clarence Capone .....

Licensed Embalmer No. 4755  
P. O. Address 1221 N. Main

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.